Supreme Court, U.S.
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~~(No. 97-5909)~~

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM 1998

LINDA ALLINDER,
Petitioner,

v.

INTER-CITY PRODUCTS CORPORATION (USA), and
ROBERT HENNINGSEN,
Respondents,

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether there is federal subject matter jurisdiction in this case where this case was removed to federal court pursuant to 28 U.S.C. §1331 because there was alleged to have been a federal question pursuant to the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1101 et seq., but where neither the district court or Court of Appeals below asked whether a plan existed or asked whether fiduciary status existed, and no proof was produced to establish those facts and, therefore, would qualify this case for federal jurisdiction.

2. In the alternative, whether the Court of Appeals below applied the wrong standard in granting relief to the respondents when it predicated its holding on the fact that the respondents were fiduciaries to the ERISA plan, but applied the standard announced in *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993), in which the holding there was predicated on the question whether ERISA authorizes suites money damages against *nonfiduciaries* to an ERISA plan.

3. In the alternative, whether the Court of Appeals should have applied the standard announced in *Varity Corp. v. Howe*, 116 S.Ct. 1065 (1996), which allows an individual to obtain equitable relief against a fiduciary to an ERISA plan, where the Court of Appeals predicated its holding on the fact that the respondents were fiduciaries to the ERISA plan.

PARTIES TO THE PROCEEDING

In addition to the petitioner, Linda Allinder, who appeared as Plaintiff-Appellant in the Sixth Circuit proceeding with her Attorney of Record, James L. Harris, and Brian O. Bowhan, attorney at law, joined the petitioner in her cause as co-counsel in the Petition for a Rehearing at the Court of Appeals and is also Attorney of Record; and respondents, Inter-City Products Corporation and Robert Henningsen, appeared as Defendants-Appellees before the Sixth Circuit.

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1. This case is rooted entirely in state law and there is no federal subject matter jurisdiction under 28 U.S.C. §1331 as ERISA does not apply here because there is no employee benefit plan, but only an insurance policy purchased by the respondents.

2. In the alternative, the Court of Appeals decided this case on the assumption that the respondents were fiduciaries to an ERISA plan, but the court predicated its decision pursuant to the this Court's holding in *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993), but the only issue in *Mertens* was

whether a beneficiary could bring an action for money damages against a non-fiduciary, but the questions of fact and law rooted in the *Mertens* decision do not apply here because the respondents here would have had to have been fiduciaries and, therefore, subject to an action for money damages.

3. **Alternatively, if ERISA applies, the Court of Appeals erred in denying appropriate equitable relief.**

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Appendix A
Order Affirming the Judgment of the District Court which dismissed this case. **A1**

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The order of the United States Court of Appeals for the Sixth Circuit affirming the order by the United States District Court is reproduced in the petitioner's appendix at A1. The order of the United States Court of Appeals for the Sixth Circuit denying the petitioner's petition for rehearing is reproduced in petitioner's appendix at A20.

JURISDICTION

The order of court of appeals was entered on August 10, 1998. (A1). Petitioner filed a timely petition for rehearing which was denied by the court of appeals on August 31, 1998.
This Court has jurisdiction under 28 U.S.C. §1254(1).

STATEMENT OF THE CASE

Procedural history.

This petition arises out of a removal to federal court of a case originally filed in state court pursuant to 28 U.S.C. §1311. The reason for the removal was the assertion that this case was governed by ERISA (29 U.S.C. §1101 et seq.) and was, therefore, preempted. That case was dismissed without prejudice. This case was subsequently filed in federal court where summary judgment was entered against the petitioner. The court of appeals affirmed and denied the petition for a rehearing. This Petition for a Writ of Certiorari followed.

The facts.

The case arose when the petitioner, an employee of the

respondents', became disabled because she was exposed to a pesticide in her work area at the respondents' facility. Because the exposure to the pesticide disabled the petitioner to the extent that she could no longer work, she was involuntarily terminated from employment in August 1990.

Because the Respondent Inter-City Products Corporation (USA) (hereafter, Company), had purchased a long term disability policy, the petitioner attempted to file a claim for long term disability benefits under the policy. When she requested, at first verbally, then in a letter from her attorney, that her employer fill out its portion of the disability claim form, the Company refused to do so.

The petitioner then wrote a letter to the Vice President of Human Resources for the Company, Respondent Robert Henningsen, asking him to reconsider. He refused to reconsider stating that the petitioner was not an employee at the time of her claim. The Company conceded during oral argument at the Court of Appeals that their representation that the petitioner had to be an active employee at the time she made a claim for disability insurance benefits was false.

The petitioner then hired an attorney who negotiated a "side agreement" with the insurance company who sold the policy to the Company. As a result of the negotiations, the petitioner filled out the Company portion of the claim form and submitted the completed form directly to the insurance company. The insurance company then paid the petitioner her benefits to which she was entitled under the policy in a lump-sum payment. The lump sum did not include interest. The terms of the insurance policy were violated by this tardy lump sum payment because the payments were to be made monthly.

Because of the treatment she had received at the hands of the respondents, the petitioner filed suit in state court stating claims for conversion, tortuous interference with contractual rights, and misrepresentation. The respondents then removed the case to federal district court pursuant to 28

U.S.C. §1331 where the case was dismissed without prejudice because all of the petitioner's theories were rooted in state law.

Under the civil enforcement provisions of 29 U.S.C. § 1132 (a)(3) and §1132(c), the petitioner refiled her case in federal district court alleging that the Company violated ERISA when it refused to complete its portion of the claim form under §1132(c) and for a breach of fiduciary duty §1104(a)(1) and§1106(b)(2).

At no time during any of the proceedings in any of the two cases, that is neither in the first case which was removed to federal court and then dismissed without prejudice nor in the second case which is before this Court now, did the respondents produce a plan which would qualify the long term disability policy to be a plan under ERISA. Further, neither the district court nor the Court of Appeals inquired whether there was a plan or made a finding that a plan existed under ERISA. It follows that neither court inquired whether the respondents were fiduciaries or even if the petitioner was, in fact, a beneficiary under a plan.

REASONS FOR GRANTING THE WRIT

1. **This case is rooted entirely in state law and there is no federal subject matter jurisdiction under 28 U.S.C. §1331 as ERISA does not apply here because there is no employee benefit plan, but only an insurance policy purchased by the respondents.**

The petitioner raises the issue of subject matter jurisdiction because this case was filed in federal court after

the federal district court dismissed the original action without prejudice. That original action was previously filed in state court, but was removed to federal district court by the respondents pursuant to 28 U.S.C. §1331 citing that a federal question was involved and, that pursuant to ERISA, the action was preempted. After the federal district court dismissed that action without prejudice because only theories under state law were pled, the petitioner, relying on the respondents' ERISA theory and the subsequent concurrence of the district court, filed this case in federal district court citing a claim under the enforcement provisions of ERISA.

After careful review of the respondents' theories, e.g., that this cause is pre-empted by ERISA, the petitioner now concludes that ERISA does not apply and there is no federal preemption or even subject matter jurisdiction. What is really involved is that the company purchased an insurance policy only and did not establish an employee plan within the scope of ERISA. Although insurance policies only are not covered by ERISA, the appellant has not raised the issue of subject matter jurisdiction until her Petition for a Rehearing was before the Court of Appeals.

The issue of whether subject matter jurisdiction exists can be raised at any time, either at the trial level or appellate level. *Clark v. Paul Gray, Inc.*, 306 U.S. 583, 59 S.Ct. 744, 83 L.Ed. 1001 (1939), see, *Beck v. Miriani,* 293 F.2d 333 (6th Cir. 1961). Since this issue goes to the inherent power of the federal courts to entertain the case, the parties may not agree or consent to create jurisdiction. *Nierbo Co. V. Bethlehem Shipbuilding Corp.*, 308 U.S. 165, 60 S.Ct. 153, 84 L.Ed. 167 (1939). Further, the failure to raise the issue of subject matter jurisdiction at an earlier stage of the proceeding cannot be deemed to be a waiver as the issue of subject-matter jurisdiction cannot be waived. *Alliance of America Insurers v. Cuomo,* 854 F.2d 591 (2nd Cir. 1988). It follows that even if a plaintiff pleads a theory under federal law in response an

affirmative defense, and if both parties mistakenly litigate under a federal theory that really does not exist, which is what happened here, that mutual mistake cannot convey subject matter jurisdiction where none exists.

Indeed, the entire strategy used by the petitioner when she allowed the dismissal to go down in the original action without an appeal was one of acquiescence to the court's holding and the respondents theory that ERISA did apply to her case and she, therefore, believed that the appropriate forum for her claim was in federal court. When the petitioner subsequently re-filed her cause in federal district court on the theory that she could recover money damages from the respondents because of an ERISA violation, she was unable to produce a plan. Rather, she consistently referred to the long term disability insurance policy identified above.

The petitioner now realizes that she needs to prosecute her claim in state court because her cause of action is only rooted in state law. Although she now believes the summary judgment entered against her is void because the federal courts do not have jurisdiction, she may not be able to re-open or re-file there for two reasons.

First, as long as summary judgment which has been entered against her in federal district court stands, she will probably not persuade the state court that the summary judgment in federal court is without effect as to her claim. Therefore, the petitioner is faced with the practical result that her claim may by barred by *res judicata* or *collateral estoppel*. Thus, this entire jurisdictional question of whether ERISA applies must be made here in federal court because as long as the federal preemption issues remain decided in federal court, the petitioner opens herself to sanctions if she reopens her case in the state court.

Second, if the petitioner desires to re-file in state court, the applicable statute of limitations in the state where she originally filed, Tennessee, may have run and her only

hope is to re-open the original case.

The burden of proof on subject-matter jurisdiction rests with the party asserting it. *Adams v. Bain,* 697 F.2d 1213 (4th Cir. 1982). The respondents originally asserted federal jurisdiction. That the petitioner now challenges federal jurisdiction does not shift the burden from the respondents to the petitioner. The respondent must come forward with competent proof of jurisdiction. *Grafton Corp. v. Hausermann,* 602 F.2d 781 (7th Cir. 1979). The respondents have not cited any facts, including those recited in their original notice to have the case removed to federal court, which show that the policy at issue qualifies as an ERISA plan.

As discussed above, the first time that the petitioner has raised this subject matter jurisdiction issue was in her Petition for a Rehearing in the Court of Appeals, but, for the reasons stated above, the failure to do so cannot prejudice her in any way. The petitioner asserts that the long term disability policy, which is claimed by the respondents to be an ERISA plan, is nothing more than an insurance policy. That policy cannot pass the litmus test which would qualify it as an ERISA plan.

All the respondents' Notice of Removal, which was filed in state court, stated was that removal of the case to federal court was necessary because ERISA preempted all of the state law claims. Their assertion that there was a plan was conclusory with no verification that there was a plan which satisfied standard of the statute. The federal trial court's Order and Memorandum, which dismissed the original case on the pleadings, contained no finding that a valid ERISA plan existed, or that the respondents were fiduciaries under the plan, and the issue has never been argued or briefed by either party. Essentially, this entire matter has proceeded in federal court by implied consent of the parties and the courts.

In order to show that a plan exists which will meet

certain minimum standards under ERISA, the respondents must demonstrate (1) they are employers engaged in commerce (29 U.S.C. § 1003(a)), (2) that there must be a plan for the purpose of providing certain benefits (29 U.S.C. §1002(1)), (3) there must be a written instrument providing for fiduciaries, and (4) that the assets of the plan must be held in trust by trustees to manage and control the assets of the plan (29 U.S.C. §§1102, 1103).

With the foregoing standard in mind, a federal district court found that an employer plan could not qualify as an ERISA plan in the absence of an affirmative showing that the above identified minimum criteria had been met. *National Metalcrafters, A Division of Keystone v. McNeil*, 602 F. Supp. 232, 235-6 (N.D. Ill. 1985), rev'd. on other grounds, 784 F.2d 817 (7th Cir. 198_). There the court noted that the employer failed to show that there was an established fund, there were no named beneficiaries, or fiduciaries. Further, there was "no evidence of a summary plan description, no annual reports, no trust agreement, which would lead the court to conclude that (the plan) was an ERISA fund...." *Id.*

Here, it appears from the facts, as recited by the Court of Appeals in its opinion at page A6, that the court recognized that the petitioner's attorney negotiated a "side agreement with the insurance company." That statement alone should have raised two red flags. The first red flag should have been on the face of the statement that the court recognized there was a side agreement. There is virtually no way in which a plan can act without the trustee or fiduciary. 29 U.S.C. §1102. Therefore, it would have been impossible to negotiate a "side agreement."

The second red flag raised should have been that there was an insurance company involved in the side agreement. Under the ERISA scheme, insurance companies cannot be a benefit plan or a trust established under the plan, unless the plan's primary purpose is to provide death benefits. 29

U.S.C. §1144 (b)(2)(A). The insurance policy in this case is a long term disability policy. The reason for that rule is probably that there would necessarily be a commingling of funds with other assets of the insurance company to the extent that the plan assets would lose their identity.

Again, in order to qualify as a plan, there must be a corpus which is held in trust by trustees who manage and control the plan. Those trustees are the fiduciaries. All of the participants must be identified in the plan. Those elements are patently missing here. There is a vast distinction between an employer buying an insurance policy and an employer establishing an ERISA plan, and the purchase of insurance alone does not prove that a plan has been established. In this case, there was never a query made as to the existence of an ERISA plan after the insurance policy had been identified.

But, ERISA does not regulate the bare purchase of insurance if the employer who purchases the insurance neither directly nor indirectly owns controls, administers, or assumes responsibility for the policy or its benefits. *Taggart Corp. v. Life &Health Benefits Administration,* 617 F.2d 1208 (5th Cir. 1980). In other words, if a plan looks like an insurance policy and not a plan, then it is an insurance policy and not a plan. Here, the facts and circumstances observed by the district court and the Court of Appeals do not predispose one to conclude that an ERISA plan exists. Rather, one is predisposed to conclude that what is involved here is an insurance policy and not an ERISA plan.

Again, the Court of Appeals recognized in its opinion at page A6 that the petitioner negotiated with the insurance company a "side deal" where she filled in the respondent's (employer's) portion of the claim form and then submitted the completed form to the insurance company, which then processed the petitioner's claim and paid her.

But, if there was a plan with a fiduciary, the question which both the district court and the Court of Appeals below

did not address was this: how was it that money was paid to the petitioner by the insurance company without authorization from a fiduciary? The next question should have been; how is it that there was a company portion of an insurance claim form to be filled out which could be circumvented? The answer to both questions is that under an ERISA plan, only the trustee can administer the plan and the side deal would not have been possible because an ERISA plan cannot be circumvented by a third party.

This court in *Lockheed Corp. et al., v. Spink*, 517 U.S. 882, 116 S.Ct. 1763 (1996) stated that it was error for the Court of Appeals not to ask whether fiduciary status existed before it found violations of a fiduciary's duty. It follows, therefore, that the parties involved in ERISA litigation must first establish the facts that a plan exists by establishing the plan instrument, and who the fiduciaries and beneficiaries are. In other words, it appears from the court's admonition in *Lockheed Corp., Id.*, that it is the duty of the court to insure that the parties make a *prima facia* showing of the existence of a plan and it may be reversible error not to do that. The required *prima facia* showing was not made in this case and the petitioner does not believe that it can be made because there is no ERISA plan.

The failure of those courts to require that the parties establish that there was a plan and to establish who the fiduciary was plain error. The result of that error is that the petitioner, as a practical matter, is bound by a judgment which is invalid because the federal courts have no subject matter jurisdiction over her claim.

The only privity in a valid ERISA plan is between fiduciary and beneficiary; not between employer and employee. The lines of demarcation are clear cut and not readily capable of dilution or circumvention. 29 U.S.C. §§1002, 1102, 1103.

The overriding fact here is that the insurance

company, who could not be a fiduciary, acted entirely on its own when it authorized the "side deal" and rightly paid the money to the petitioner without the authorization of the respondents. Indeed, there has been no showing that the respondents had any control over the insurance policy. It is inconceivable for that to happen under an ERISA plan. In other words, the only one who could make the check would be the trustee, who could not have been an insurance company.

Finally, as shown above, ERISA plans must designate a fiduciary. Throughout this entire case no one has identified who the players are. There has been no showing of who the fiduciary is or how the plan is identified. Also, the tort and breach of contract claims asserted in the original complaint were against the respondents and not against an ERISA plan. In any event, as they have not claimed fiduciary status, the state actions against the respondents cannot be preempted. *Simmons v. Prudential Ins. Co.*, 641 F. Supp 675 (D.C. Colo. 1986); *Lessard v. Metropolitan Life Ins. Co.*, 618 F. Supp 1268 (D.C. Me. 1985). The petitioner does not believe that the respondents can claim fiduciary status or any other special protection under ERISA because they did act in any role under ERISA.

It is absolutely imperative that the Writ be granted in order that the Court can dismiss this case or remand it to the district court in order that the most fundamental factual determinations be made in order to determine whether an ERISA plan exists. Courts cannot just create jurisdictions for themselves and they cannot retain jurisdiction where none exists.

2. **In the alternative, the Court of Appeals decided this case on the assumption that the respondents were fiduciaries to an ERISA plan, but the court predicated its decision pursuant to the this Court's holding in *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993), but the only issue in *Mertens* was whether a beneficiary could bring an action for money damages against a non-fiduciary, but the questions of fact and law rooted in the *Mertens* decision do not apply here because the respondents here would have had to have been fiduciaries and, therefore, subject to an action for money damages.**

Assuming, *arguendo*, that there was a plan, there has never been a finding, either by the trial court or by the Court of Appeals in what capacity under the ERISA plan the respondents acted. Indeed, the respondents have never asserted whether they either did or did not act as a fiduciary. The petitioner may have earlier alleged that but, as discussed above, those assertions were probably misplaced as she had no proof of the allegation and there has never been any proof by way of the plan instrument that the respondents were fiduciaries. The allegation that the respondents are fiduciaries was not part of the original allegations made in state court. Indeed, it appears they were made more by implication and only in response to the respondents' maneuver to remove this case to federal court. That point is important to reemphasize because without a finding of the proper role of the respondents, proper relief, if any, cannot be rendered.

At page A16 of the Court of Appeal's opinion, the court seemed to base its holding on *Mertens v. Hewitt Assoc.*,

508 U.S. 248,113 S. Ct. 2063, 124 L.Ed 2d 161 (1993) which addressed only whether a suit for money damages could be brought against a non-fiduciary to a plan. The Court of Appeals' holding was clearly predicated on the assumption that the respondents were fiduciaries to a plan. The Court of Appeals recited again and again what the appropriate relief was against a fiduciary. The Court of Appeals, with a view toward its misreading of *Mertens,* took one more step and stated that there was "nothing in the legislative history... to insure that plan *fiduciaries* faithfully execute their ministerial function of completing claim form for individual plan participants." Opinion at page A11. (Emphasis added). That statement was a complete misstatement of this Court's policy. The Court of Appeals cited no authority for its shocking proposition that a fiduciary to an ERISA plan could intentionally withhold claim forms from a plan beneficiary and, thereby, deprive said beneficiary of express benefits.

Again, the sole question in *Mertens* was "whether ERISA authorizes suits for money damages against *nonfiduciaries* who knowingly participate in a fiduciary's breach of fiduciary duty." *Id.* at 251. (Emphasis added). There the court was faced with petitioners who tried to shoehorn a malpractice case against an actuary, with whom they apparently had no privity, into a cause of action under ERISA. The court did not buy the theory and denied relief. On the other hand, here the implied theories were predicated on a fiduciary's breach of duty.

Further the Supreme Court's holding in *Varity Corp. v. Howe*, ___ U.S. ___, 116 S.Ct. 1065 (1996), which applies to a suit by a petitioner against a fiduciary, which is the theory asserted by the petitioner here, does not close the door on money damages for the petitioner. In *Varity,* the court began "with the question of Varity's fiduciary status." *Id.*, at 1071. It then made a finding that Varity was a fiduciary. *Id.* Then the court held that individual relief against a plan was

authorized under ERISA. *Id.*, at 1079. Essentially the court held that an individual can obtain equitable relief. *Id.* Here, among other relief, the petitioner is going to seek equitable relief in the form of restitution.

With a view towards the court's decision in *Varity,* which is a fiduciary case and the Court of Appeal's decision which was predicated on this Court's holding in *Mertens,* which is a non-fiduciary case, the conclusion is clear that the Court of Appeal's reliance upon the holding in *Mertens,* without a finding somewhere in the history of the case that the respondents are nonfiduciaries, is clearly misplaced. That is especially true here where the entire basis of the Court of Appeal's holding seems to be rooted in the assumption that the respondents are fiduciaries.

3. In the alternative that this court decides 1.) The insurance policy is an ERISA plan, and 2.) The respondents were fiduciaries, the Court of Appeals erred by deciding that the petitioner was not entitled to some form of equitable relief.

As the Supreme Court states in *Mertens*, p. 2068, 'a remedy traditionally viewed as "equitable" [is] an injunction or restitution.' The petitioner asked the courts to provide her with "appropriate equitable relief", as provided for by S1132(a)(3).

The petitioner had to pay her representative approximately one-fifth of her lump sum disability payment in order to obtain it. The respondents should make restitution of that amount with interest. Her attorney obtained the funds by an administrative agreement with the disability insurance company and not by legal means. The petitioner would like to ask the court to make her, as a victim, "whole for a breach of trust." *Id, 2074.*

Additionally, as the petitioner previously argued, she

is entitled to interest because interest is not and should not be considered extra-contractual damages. Appellant's policy stated that she was to receive benefits when due, not in a lump sum five years later. The petitioner contends that interest is a form of allowable restitution since running back the clock and instructing that payments be made to her monthly would be an impossible form of restitution.

The petitioner, at one point, conceded that ERISA did not provide for compensatory, punitive, or extra contractual damages. She conceded this only because the District Court in their Opinion stated that ERISA did not provide them. Subsequently, she has learned that the District's Courts stance on this point is incorrect. She believes that it would be unfair to hold her to this concession in light of these facts.

As *Varity* states on page 1078, ' The statute [ERISA] itself says that it seeks " to protect . . . the interest of participants . . . and beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries . . . and . . . providing for appropriate remedies . . . and ready access to the Federal courts." ERISA § 29(b). Section 404(a), in furtherance of this general objective, requires fiduciaries to discharge their duties "solely in the interest of the participants and beneficiaries." Given the objectives, it is hard to imagine why Congress would want to immunize breaches of fiduciary obligation that harm individuals by denying injured beneficiaries a remedy.'

To allow fiduciaries to act in a flagrantly harmful manner toward beneficiaries with absolute impunity only encourages fiduciaries to do so. The Supreme Court states in *Mertens*, p. 2068, ' . . . we have never interpreted the precise phrase "other appropriate equitable relief." This case offers the Supreme Court an opportunity to do so because it offers the appropriate factual situation and theories. It is this petitioner's contention that this honorable Court can pave the way for a proper interpretation of the aforementioned sections

of ERISA.

CONCLUSION

For the reasons stated above, the Court should grant the Writ of Certiorari.

Respectfully submitted,

/S/ _____

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